

Lunar Screening Form upon Admissions

INTERVIEWER NAME: _____ *****DATE: _____
yyyy mmm dd

Applicant Data

Applicant Name _____ Age _____ D.O.B. _____
MMM DD YYYY

PHN: _____ S.I.N _____ Tel: _____

Length of abstinence as of today? _____ or Clean Date: _____

Are you an IV drug user? Yes No

Are you on a methadone maintenance program? Yes No (If so, please complete MMT Questionnaire)

Is this your first time accessing any alcohol and drug services? Yes No

Current Program or Address where you are now: _____

A&D Counsellor or Case Worker _____ Tel: _____

How did applicant hear about Phoenix? _____

Do you have TB test results? Yes No Referred to Sessional Physician for testing? Yes No

Marital Status: Single Common Law Married Separated Divorced Widowed

Employment Status: Unemployed Employed Not in the Labour Force Student Retired

Homelessness Status: Are you currently homeless? Yes No

Are you currently at risk of homelessness? (Couch surfing, staying with friends or family) Yes No

Education: University Degree College/Diploma Grade 9-12 Grade 1-8 Trades Training

APPLICANTS' SELF ASSESSMENT OF FUNCTIONING OR CIRCUMSTANCES

The purpose of this (pre-test) survey is to gather information from applicants on how they rate their circumstances in the following areas. When talking with the applicant, you might try a conversational approach like this: I have to gather some information from you now that asks you to rate how you are doing in a variety of areas. One of these is substance use. I would guess that since you are applying for treatment that you would rate your circumstances as poor. Am I right? And for housing; well you told me you are homeless. Is "poor" the right answer in that area? (And so on).

	POOR	FAIR	GOOD	EXCELLENT	N/A
Substance use/misuse					
Physical health					
Mental/emotional health					
Family					
Friends					
Educational					
Employment					
Legal					
Housing					

Substance Use History (including tobacco)

Substance used	How	Age you first used this drug	How long have you used substance?	How much have you been using in the last 2 weeks?	When did you last use the substance? mm-dd-yyyy	Is it the Primary Drug of Choice?
	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal					Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal					Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal					Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal					Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal					Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal					Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal					Yes <input type="checkbox"/> No <input type="checkbox"/>

Health**Do you have any diagnosed Physical Health Conditions**

Heart Disease Diabetes Back Injury Pain Management Issue HEP C HIV+ AIDS

Food Allergies to

Medication Allergies to

Upcoming surgeries for

What is your worst medical health problem right now?

WHAT CURRENT MEDICATIONS ARE YOU TAKING?

Medication Name	Dosage	How many times per day	How long have you been taking this medication?

I am taking these medications regularly Yes No If not, why not?

Do have any Diagnosed Mental Health Conditions		
Diagnosis	At what age:	Psychiatrist <input type="checkbox"/> Family Doctor <input type="checkbox"/> Other <input type="checkbox"/>
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CURRENT MEDICATIONS FOR MENTAL HEALTH			
Medication Name	Dosage	How long have you been taking this medication?	How many times per day

Are you taking these medications regularly now? Yes No If not, why not?

Health – Suicide Risk

Have you ever felt suicidal? Yes No How recently?

Have you ever made an attempt? Yes No how recently?

By what method?

Where you hospitalized? Yes No How long was your stay in hospital?

Were you seen by a psychiatrist? No

Name:

Medical Contacts

Medical Contact	Name	Telephone
Physician		
Specialist		
Psychiatrist		
Other		

Notes:

Treatment History			
Dates of Treatment	Type: Detox, Support Recovery, Outpatient (OP), 28 day Treatment Program	Facility Name	Completed or incomplete (If incomplete, why?)
Clean Time History (Other Periods of Abstinence)			
From		To	What happened that started your substance use again?
Motivation for Treatment Now			
Why do you want to apply for treatment now?			
What is different for you this time as you are thinking about coming back to treatment?			
What is your worst problem right now?			
Do you have a 12 Step sponsor? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you seeing an outpatient counselor regularly? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Are you attending support meetings? Yes <input type="checkbox"/> No <input type="checkbox"/> How many per week?			
What are the 3 main goals you want to accomplish while you attend the program?			
Are you ready and willing to be in a highly structured program for a minimum of 3 months? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Are you ready and willing to enter the program as soon as possible Yes <input type="checkbox"/> No <input type="checkbox"/> If no, why not			
Do you have any outside problems that might prevent you from completing the program? (Relationships with spouse/partner, parents, kids, money, loss of job, loss of home, etc.) Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what are they?			

Employment History and Goals

If you are unemployed, how long have you been unemployed?

If you are employed, how long have you been employed?

What kind of work do you do?

What kind of work would you like to do?

What are the main employment action plan goals you want to accomplish?

Educational Goals

Do you need help with education, skills or training to find and keep employment? Yes No

What are the main educational action plan goals you want to accomplish while in this program?

Criminal Justice Involvement History

Do you have a criminal record? Yes No

Charged with:

When

Have you been arrested, in custody?

Convicted, not in custody

Have been arrested, not in custody

Convicted, currently in custody

Are you facing any current charges? Yes No What are the charges?

Are you on probation currently? Yes No If yes, what are the conditions of your order?

Do you have upcoming court dates? Yes No Date:

Probation/Parole Officer Name:

Contact Number:

Sources of Income

Type	Amount per month	Comments
Employment	\$	
Employment Insurance	\$	
Employer (Union, EAP)	\$	
Income Assistance (Basic)	\$	
Income Assistance (Disability)	\$	
Income Assistance (PPMB)	\$	
Accommodation Fee Subsidy (ADS)	\$	
Self-pay	\$	
CPP	\$	
Other	\$	

Housing Status		Housing Composition	
Aboriginal Housing	<input type="checkbox"/>	Living Alone	<input type="checkbox"/>
Supported Facility	<input type="checkbox"/>	Living with Non-Relative	<input type="checkbox"/>
Own Home	<input type="checkbox"/>	Living with Relative(s)	<input type="checkbox"/>
Supported Housing	<input type="checkbox"/>		
Correctional Facility	<input type="checkbox"/>		
Rent or Room/Board	<input type="checkbox"/>		
NFA – No Fixed Address	<input type="checkbox"/>		

Family and Friends	
Are family and friends supportive? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have a significant other who is supportive of your recovery? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have children?	
No current dependent children <input type="checkbox"/>	Yes, children in others care <input type="checkbox"/> Not applicable <input type="checkbox"/>
Yes, currently providing care <input type="checkbox"/>	Both – providing care & in others care <input type="checkbox"/>
Are you hoping to reunite with your family? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are there others who are supportive of your recovery? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Hopes and Dreams
What are your hopes and dreams that you would like to achieve while in the Transition housing program?

<input type="checkbox"/> Approved for ESTLR Date: _____ <input type="checkbox"/> Through STAR Estimated Intake Date: _____
<input type="checkbox"/> Not Approved Ineligible because: